A National Agenda for Rural Minority Health

A Strategic Planning Document Developed by the

Rural Minority Health
Work Group

February 1997

with Recommendations for Implementation
Developed by Participants of the

3rd Annual
Rural Minority Health
Conference

December 11-13, 1997
Charleston, South Carolina

Sponsored by the

National Rural Health Association

Funded by

Office of Rural Health Policy, HRSA
Division of Community and Migrant Health, Bureau of Primary Health Care, HRSA
Office of Minority and Women's Health, Bureau of Primary Health Care, HRSA
Centers for Disease Control and Prevention, DHHS

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Executive Summary

Recently, there have been efforts directed toward better understanding and addressing the unique health issues of rural minority populations. In 1991, the National Rural Health Association (NRHA) convened a group of health care professionals to begin discussions about the gaps in health services for this portion of the population. That group developed a list of concerns that led the NRHA to establish a Rural Minority Health Advisory Committee in 1992. An invitational meeting was convened in Albuquerque, N.M., Nov. 18-20, 1993, for health care providers, faculty and policy-makers to join in the discussion of concerns being researched by the advisory committee. This meeting was jointly sponsored by the Division of Community and Migrant Health Centers, Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA); the Office of Rural Health Policy, HRSA; and the Robert Wood Johnson Foundation. The meeting resulted in published proceedings, *A Shared Vision: Building Bridges for Rural Health Access*, that documented the gaps in access to health services for rural minority populations and prompted the NRHA to begin convening annual rural minority health meetings to share information on accomplishments in this area.

The first NRHA Rural Minority Health Conference was convened in Long Beach, Calif., March 16-18, 1995. This meeting was designed to address the agenda published in the 1993 proceedings. At that meeting, representatives from health and health-related fields presented topics of concern to rural minorities and sovereign nations. The overall objective of this meeting was to become more knowledgeable about similarities and differences in needs and culture among rural minority populations.

The second annual conference was convened in Birmingham, Ala., Sept. 25-28, 1996. As a result of that conference, the Office of Minority and Women's Health, BPHC, HRSA; the Office of Rural Health Policy, HRSA; the Centers for Disease Control and Prevention (CDC), DHHS; and the Office of Minority Health, Department of Health and Human Services (DHHS), under the auspices of the NRHA, jointly supported a working group meeting of rural health experts. The fact that there is no national policy or focus on rural minority health was underscored during the meeting, which was held Feb. 20-23, 1997, in Tucson, Ariz. Indeed, the *Health People 2000 Review 1995-96*, published by the National Center for Health Statistics, CDC, DHHS, is silent regarding the need to collect and analyze data specific to rural minority populations. The objective of this special meeting was to move beyond problem identification to problem solving and to develop a rural health agenda to address the access gaps and the growing disparities in health status indicators for rural minority populations.

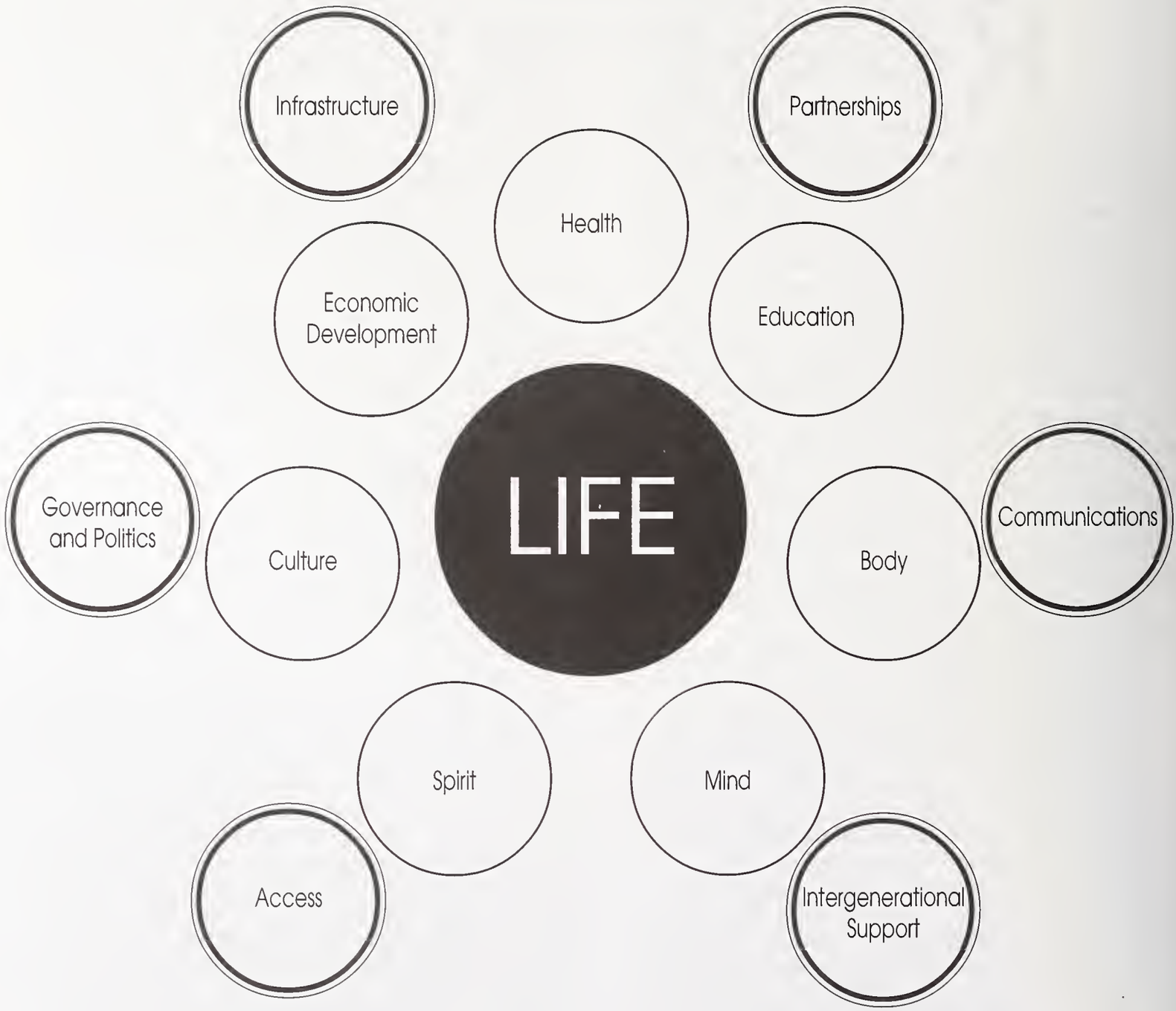
The sponsoring agencies charged these experts with the responsibility of developing a national agenda and strategies for action to close the identified gaps by the year 2002. At the meeting, the working group organized itself around three priority areas:

- information and data,
- health policy and practices, and
- health delivery systems.

Several priority issues were agreed on, along with some initial recommendations, strategies and action plans. The outcome of that meeting was the development of a draft national agenda and strategic plan, highlighting objectives and implementation strategies for the three priority areas.

The process was continued at the third annual rural minority health conference, "Rural Minority Health: Issues for the 21st Century," with the preliminary development of an annual action plan for carrying out the *National Agenda for Rural Minority Health* strategic plan, as well as the process of identifying partners to participate in this process as it develops and comes to fruition. This conference, conducted in Charleston, S.C., Dec. 11-13, 1997, addressed essential requirements of an effective partnership, which includes the active involvement and voice of those at-risk populations in designing their future. The *National Agenda for Rural Minority Health* was thus taken to another level in its development and implementation activities, which included approval of the strategic plan with recommended changes and modifications as reported here from that conference.

Rural Minority Health Is in Each of These Aspects of Life



Vision Statements

The working group developed a document that can be used in a prescriptive manner by states and local health and health-related agencies for setting priorities and community funding for major rural minority health initiatives. Using data identification, collection and analysis, systematic research and action planning, programs to ultimately eliminate health care disparities and achieve access to tailored primary preventive health care services can be developed and implemented. Such an approach can improve the quality of life for rural minority at-risk populations (African Americans, Asian and Pacific Islanders, Hispanic Americans, Native Americans and Alaska Natives) in the United States. This will be achieved through collaboration, education, creativity and cooperation between and among rural minority communities, other health entities and health policy-makers.

This document is envisioned to be a "living" and dynamic one, designed for on-going use, modification and adoption by various entities. Opportunities for change are built into the document, allowing it to serve as an evolving national rural minority health agenda and as a catalyst for policy and program development. The document includes specifically focused vision statements and implementation strategies for use by multigenerational, rural minority communities in the next millennium.

Each of the visions included in this document are summarized in the following narrative. Following this section, each vision is explored individually and is broken down into "issues of concern," or areas of concentration, i.e., environmental health, community sensitivity and the like. Each of these issues of concern are then broken down into subheads identifying steps to be taken to address these issues, including recommendations, tasks, resources, etc. Recommendations identify those events that need to occur to address the issue of concern, summaries define the goal of the recommendations, tasks identify those activities and actions that need to occur to accomplish the recommendations, questions identify areas that will need to be addressed to fully address that issue of concern, and resources identify those agencies, organizations or tools available and/or needed to accomplish the related tasks. The result is a complete plan of action to address each of the visions identified in this national rural minority health agenda.

Vision: Information and Data

Currently, there are sparse and inconsistent health-related data on rural minority communities—by the year 2002, there will be adequate data concerning the health status, health care utilization patterns, health care financing and health outcomes for *all* rural minority populations. Furthermore, rural minority communities will routinely participate in the planning of data collection concerning their needs and experiences with health, illness and the health care system. Minorities will actively participate in interpreting and using data to plan changes and make decisions to improve health care delivery in their communities. Data collection systems will incorporate core data sets and employ uniform definitions for relevant terms, so that information can be compared among and across minority populations. Data analyses and the interpretation of findings also will reflect sensitivity to the unique cultural attributes of the population on which data are being collected.

Vision: Health Policy and Practices

Through this work group's proposed agenda, by the year 2002 our nation will have achieved a system of health care that provides comprehensive health care services for multigenerational, rural minority populations.

Policies will be developed at the state and local levels that ensure access to comprehensive health services, regardless of ability to pay. Throughout the health care system, all providers will practice preventive measures by providing health education to all patients. As a general practice, health professionals will focus on prevention by advocating lifestyle modifications and regular physical check-ups. Comprehensive health services will be measured by the level of quality of care being provided, access to essential services, and the offering of services that are affordable to rural minority populations.

Vision: Health Delivery Systems

Health care is a right—not a privilege. Given this premise, health care delivery systems must be developed by the year 2002 that substantially improve the health status of rural minority populations. These health care services must be:

- linguistically and culturally appropriate for the community;
- based on the assessed needs of the community;
- responsive to the community's input;
- linked to other health and community systems;
- cost-effective;
- accessible to all rural minority populations; and
- situated within an integrated network of health services and systems.

These respective vision statements are motivated by the values presented in the following section.

Shared Values

The underlying values that motivated the development of this national rural health agenda are reflected in this strategic plan. The genesis of this process is contained in a charge by Arlene Granderson, director of operations, ORHP, delivered during the NRHA's 1993 Rural Minority Health Conference, "A Shared Vision: Building Bridges for Rural Health Access." She stated that we "need a dynamic document that can be implemented for the next five or more years—however long it takes to bring the changes to fruition." The overarching values coming out of that conference, which are mutually shared by the rural minority constituency groups, may be summarized as the provision of a health care delivery system for the at-risk rural minority populations, that has the aspects that follow.

- **Community Based.** Accessible to the community being served by being within reach during times of need, the community-based health care system is equitably distributed and universally available in all areas.

- **Culturally Competent.** The culturally competent system is responsive in its staffing, health care delivery, and personal interactions with patient groups, using ways that are familiar and comfortable to them to facilitate working on interdisciplinary teams. It also must be sensitive to cultural differences and modify practices to incorporate those differences, integrating traditional and western medicine as appropriate. Through developing interpersonal and inter-cultural skills in its health care delivery personnel and managing professional and personal time effectively, the culturally competent system deals with ambiguity, is flexible, creative and resourceful in providing care within the constraints of limited health care resources, and involves patients and families in the decision-making process.

- **Comprehensive.** The mix of health care modalities, services and personnel must be commensurate with identified needs, health status indicators and demographics of the community being served.

- **Creative.** Participation of patient groups and their representatives is necessary to identify emerging needs and health care problems that require new and different solutions. In this manner, solutions will recognize the unique needs, capacities and strengths of different populations, even within the same rural minority group, and incorporate traditional and western practices.

- **Community Involvement.** The development of policies and programs should involve the active participation of rural minority communities, including leaders, advocates and consumers.

- **Cost-effective.** Affordable through the allocation of funding to pay for reasonable health care services, yet distributed in ways that are designed to overcome disparities, to bring at-risk populations up to a level of health care and quality of life comparable to the population at large.

These values are further explicated in the articulation of specific goals and objectives identified by the respective strategic planning work groups.

At this juncture in a process that was initiated more than three years ago, the need for an implementation strategy is evident. Individuals from various ethnic communities who participated in the development of this strategic plan are available and motivated to continue the process with input from a broader spectrum of the stakeholders. They are agreed that the next step is approval of the final plan and development of an implementation strategy that will involve resources from the sponsoring and funding agencies, interest groups, and administrative, technical and budgetary support to facilitate developing the final document. The final plan will be used in building coalitions and partnerships, and collaborative planning, programming and budgeting actions to fund the implementation strategy.

Additionally, this agenda must be validated by the rural minority populations of concern before steps and actions are taken to implement it.

Information and Data

With the recommendations proposed by this work group, by the year 2002, there will be adequate data concerning the health status, health care utilization patterns, health care financing and health outcomes for all rural minority populations. Furthermore, rural minority communities will routinely participate in the planning of data collection concerning their needs and experiences with health, illness and the health care system. Minorities will actively participate in interpreting and using data to plan changes and make decisions to improve health care delivery in their communities. Data collection systems will incorporate core data sets and employ uniform definitions for relevant terms, so that information can be compared among and across minority populations. Data analyses and the interpretation of findings also will reflect sensitivity to the unique cultural attributes of the population on which data are being collected.

The following steps are necessary to reach this vision.

1. Identify a lead agency to "own the rural minority health agenda and move it forward through the mechanisms to maintain focus and cohesiveness. The group recommended that the NRHA serve as this leader.

2. Network with those agencies, organizations, interested persons and communities that hold a mutually shared vision presented in the strategic plan and agenda. This network should involve and utilize universities, state offices and communities in an initiative to develop partners and sustain resources in this process. Funding streams and resource allocations from that partnership should be coordinated through the NRHA as the facilitating organization in this partnership network.

3. Review each partner's need for appropriate data, policy, services and resources, using a task force to appropriately change what is needed to implement the agenda and its recommendations to the network partners.

4. Develop networked task forces as a mechanism to introduce and develop a coordinated and focused approach to address rural minority needs.

5. Include in the *National Agenda for Rural Minority Health* a preamble to drive issues, data requirements and related issues, with the objective of empowering people to help themselves.

6. Develop qualitative and quantitative methods to be incorporated as part of a multilayered, multipurpose approach to achieving the objectives of the agenda. Such data should be disseminated to partners, as well as to other interested parties, in a timely manner.

7. Address ethnic-related issues, such as the use of human subjects and informed consent, as part of the data collection and analysis process.

8. Include socioeconomic status issues as part of the data needs.

Issues of Concern

Common Terminology

Definitions used in data collection need to share common terms. These must reflect the population and its needs. The premise of "one size fits all" data should not be accepted. For accuracy, there has to be more than one goal and use of data. Inclusion of more than health statistics to encompass economic information, social indexes, and the like, must be done as well. However, there is not unity of this type of data nationwide. Moreover, available data are located in different areas and do not reflect a clear and accurate picture of the true conditions of the rural minority health status.

Recommendations

- Examine Office of Management and Budget's terms and focus on what is and is not covered.
- Retain the term "farm family" as a descriptive term that differs from rural residents or non-farm personnel.
- Refine further categories and break down data needs into categories such as those listed in the *Shared Vision* conference proceedings.
- The definitions, even the studies themselves, should be determined by who is being studied, the purpose of the study, and why the research is being conducted.
- Determine what data exist and identify additional needs and gaps within these data.
- Note trends, such as reverse migration (north to south), and other geographical concerns in future data. Use concepts of the individual, the local community, and state and national data needs to further refine these trends.
- Focus on data fitting the individual by asking the right questions and finding the best way to accomplish what needs to be done.

Summary

The collection of quality data is an issue, as is the application of quality data sets for use in policy-making and designing health delivery systems.

Tasks

Year 1

- Commission an annotated bibliography of current materials related to definitions in use today.
- Commission a review of the documents and update with papers to be made available for review of the newly developed definitions.
- Identify network resources and personnel to serve as guides in the definition process.
- Identify work already in progress and bring it into the existing network.
- Involve group members and organizations as participants in the above steps.
- Support and convene a national conference to review the definitions and develop a consensus on national use of commonly shared terms.
- Present at the above conference reviews, bibliographies and papers as commissioned by the partnership.
- Develop at this conference, as well as at other conferences, an infrastructure to sustain the implementation of the goals and objectives agreed to in the agenda.
- Identify resources and agencies to assist in these recommendations, e.g., the ORHP, the NRHA, the Office of Minority Health, foundations and commercial organizations.
- Conduct conferences, not only at the national level, but in regional settings to increase attendance and facilitate access for grassroots organizations, community members and those in the field.

Questions

- Is research a part of the data component? If not, where should research be as a topic on this agenda?
- Who owns the process itself? Who is ultimately taking charge of the agenda?

Availability

Data and information are not available for *all* health issues of concern to *all* rural minority communities. Currently, systems are not set up to address the issues presented in this statement. To do so, there must be an understanding of what exists, what it does, and how it is set up to work. To do this, there should be a focus on two axes: (1) available information and data (have), and (2) unavailable information and data (do not have).

Recommendations

- Establish a data resource directory to include people, universities, state offices, communities and other organizations involved in data collection issues related to rural minority health.
- General data and specific data are necessary. The key is to focus on specific data to reflect the cultural group and not a "one size fits all" assumption found in the generalized data.
- Methodology will be driven by this premise and should include the following aspects.
  - √ Collect primary data in regions, not just in a national level database format.
  - √ Examine current data and the upcoming year 2000 census data, and use as components in the benchmark process.
  - √ Know what already exists and identify gaps, needs and supplementary data areas.
  - √ Reflect social concepts, such as Third World poverty status, by inclusion of such questions as plumbing, electricity, etc., to detail living conditions.
  - √ Link data to the *Healthy People 2010* process as well as other data-driven initiatives.

Local Data

The need for more local level data is recognized. The development and review of mechanisms to allow this to

occur and to facilitate the process of information and data collection and utilization are necessary. To allow data to be disaggregated from the national level down through all data collection levels would require the following steps.

Recommendations

- Coordinate those data tools, mechanisms and instruments in use.
- Identify and coordinate programs that are available to address these needs.
- Maximize funding resources as coordination efforts are brought to focus on national information and data needs.
- Make data a more time-efficient tool or use in improving rural minority health by timely application of findings.
- Use technology to the fullest possible extent in the collection, analysis and dissemination process.
- Deliver findings using technological methods, such as distance learning, computer networking, teleconferencing and other technology-driven avenues.
- Realize that Third World conditions (i.e., illiteracy, lack of technical resources, computers, etc.) will hamper the technological delivery of findings, and that other avenues, such as direct teaching and newsletters, can and should be part of the delivery and dissemination process as well.

Summary

Data in all its phases must involve the community and be used to empower residents.

Tasks

Year 1 and Beyond

- Creating partnerships at all levels, with emphasis on the group involved, should be considered as a priority in the actual study.

Environmental Health

Environmental health is a major concern around which a task force should be charged to identify and evaluate areas of information and data needs. The task force also should address the coordination of a research agenda and appropriate services, using an interagency format. Included in these agencies would be the CDC, U.S. Department of Agriculture, Department of Defense, Department of Education, Environmental Protection Agency, National Institutes of Health, and the Agency for Toxic Substances and Disease Registry, all of which are currently networked. The partnership should become part of this network and be utilized in the information process. The Environmental Justice Initiative should be encouraged and used to address rural minority populations' environmental needs.

Recommendations

- Identify existing databases that comprise toxic and hazardous waste, demographics and logistics, and crosscutting areas of service delivery, to locate gaps in coverage.
- Advocate the overall collection of data relevant to these issues from a "bottom up" perspective, using a local- to national-level focus.
- Encourage formation of partnerships between and among organized agencies, groups and communities to expand involvement across all areas.
- Research how available funding is used to facilitate these recommendations and disseminate the information and data to the partnership and interested parties.

Community Sensitivity

Methods of data issues, priorities, collection and analysis that are sensitive to community needs should incorporate the following aspects.

Recommendations

- Understand the rural minority cultures that are being dealt with.
- Involve communities in all phases of the data collection and analysis process.
- Engage in activities of mutual sharing, learning and cultural literacy.

Health Policies and Practices

As a result of the following proposed agenda developed by this work group, by the year 2002 our nation will have achieved a system of health care that provides comprehensive, culturally competent, effective, linguistically appropriate, acceptable services for multigenerational rural minority populations. Comprehensive health services are measured by the level of the quality of care being provided, access to essential services, and the offering of services that are affordable to rural minority populations. The design implementation and evaluation of these services must be in concert with the rural minority population to be served.

Policy-makers in concert with community representatives must take the following steps to achieve this vision of culturally competent health care.

1. Develop mechanisms that health care delivery systems can use to achieve comprehensive health care services for multigenerational, minority populations.

2. Identify marginalized populations (uninsured, underinsured, Medicaid and Medicare recipients, undocumented persons, refugees) for inclusion within the health care network.

3. Identify and review existing legislative policies at all levels to evaluate their impact on rural minority health care to facilitate reorganization and formation of complementary systems of health care.

4. Empower the multigenerational, rural minority community to enter the legislative process as partners in the development of appropriate community health care systems.

5. Redesign the health care system so that it is flexible enough to respond to the changing needs of multigenerational, rural minority communities through ongoing evaluation and restructuring of service delivery.

6. Promote an environment that improves public health and maintains the safety of rural minority communities through a holistic focus, inclusive of sustained economic development, education, infrastructure and resource management.

7. Monitor the implementation of welfare reform to secure and maintain quality of life within the multigenerational, rural minority community.

Issues of Concern

Comprehensive Care

Develop the mechanisms that are appropriate for use by health service delivery systems to achieve comprehensive, culturally competent and acceptable health services for multigenerational minority populations. The design, implementation and evaluation of these services must be in concert with the rural minority populations to be served.

Recommendations

- Focus on *all* organizations to include those that *ought* to or can *potentially* provide or deliver services in rural areas where minority populations reside.
- Focus the development of mechanisms under this issue to a "best practices" set of models that can work on a community-by-community basis in demonstration or phased-in projects.
- Modify specific tasks to include intense review of dissemination practices for this agenda for policy purposes. Identify specific individuals for an "awareness campaign," and make use of the NRHA's annual Rural Health Policy Institute, held each February in Washington, D.C., to increase knowledge of rural minority health needs. Make people "responsible."
- Identify resources outside of the health and human services system.
- Build partnerships and collaborations among organizations and rural minority communities.

Summary

Hopefully, all of the efforts undertaken to achieve this objective have provided a trickle-down effect to the agenda. Now it can begin an upward flow, from the grassroots community level of support and adoption to the state level and upward to the national level.

Tasks

Year 1

- Review the document developed by the Rural Minority Health Work Group and the sponsors of this initiative.
- Disseminate the document to:
  - √ state offices of rural health;
  - √ all agencies, programs, universities and research centers associated with, or believed to be appropriate by all funding agencies, including the Office of Minority Health, the CDC, the Indian Health Service and Bureau of Indian Affairs, tribal governments and health organizations, migrant and community health centers, the House Rural Health Care Coalition and the Senate Rural Health Caucus, and other federal, state and local groups that choose to participate in this initiative.
- Present the document during the NRHA Rural Minority Health Conference to be held in December 1997 in Charleston, S.C.
- Present the document to NRHA members and attendees at the NRHA Annual National Conference.
- Disseminate ongoing information via roundtable discussions by the ORHP.
- Continue follow-up information sharing and data gathering among all agencies contacted in previous months.
- Make the document available to any and all who request it.
- Present the document to Rural Leadership Conference and the National Advisory Committee on Rural Health.

Year 2

- Elicit communities' grassroots involvement and establish a viable focus for activities.
- Disseminate the agreed-upon focus via broad-based distribution of the agenda for agencies' nationwide utilization.
- Conduct the final phase of the dissemination activity.
- Educate congressional officials regarding the agenda, its modifications and focus as appropriate to the representative rural minority communities.

Years 3 to 5

- Dissemination of the original document to continue as the need requires.
- Evaluate and refine the process and outcomes of this objective and related activities.

Resources

Years 1 to 5

- Office of Minority and Women's Health, BPHC, HRSA.
- Office of Rural Health Policy, HRSA.
- Division of Community and Migrant Health Centers, BPHC, HRSA.
- National Rural Health Association.
- Centers for Disease Control and Prevention, DHHS.
- Office of the Secretary of the Department of Health and Human Services.
- State and federal offices of minority health.
- State offices of rural health.
- Representatives from various minority communities.

Year 2

- Stakeholder partnerships continue to evolve.
- Federal and state elected lawmakers.

Marginalized Populations

Identify marginalized, socially and economically disadvantaged rural minority populations for inclusion within the network of care, such as uninsured, underinsured, Medicare and Medicaid recipients, homeless, undocumented, refugee and isolated people.

Recommendations

- Design and complete community assessments at the local level whenever and wherever available and applicable.
- Identify at-risk, vulnerable and marginalized rural minority communities.
- Design culturally competent and continuous community assessments at the local level.
- Set standards for culturally competent community assessments that include appropriate data collection approaches, involve the target populations, and are continuous so that communities become owners of and participants in the data collecting and planning process.

Tasks

Year 1

- Identify marginalized groups:
  - √ elicit community involvement;
  - √ establish community, professional and research partnerships;
  - √ seek consultation as needed;

- √ seek funding as appropriate;
- √ assess and review existing data (if any); and
- √ identify gaps and discrepancies in databases and real or potential at-risk rural minority communities.

Years 2 to 5

- Assess the local community:
  - √ plan, design and implement community assessments, using quantitative and qualitative approaches as appropriate for the community being studied and the extent of the needed data;
  - √ convene community stakeholders to review, verify and modify instruments as appropriate;
  - √ disseminate findings to community and other entities in a meaningful and useful manner; and
  - √ evaluate and refine process and outcomes of objectives and activities.

Long-range Plan

- Reinstate focused rural minority projects in rural research center agendas.

Resources

- Representatives from rural minority communities.
- Independent and institution-based researchers.
- Funding agencies: federal, state, regional, local, public and private entities.
- Stakeholder partnerships continue.

Legislative Policies

Review existing legislation and policies at all levels and evaluate their impact on rural minority health and the delivery of health services to rural minorities. Develop a plan for assessment of future or proposed legislation and policies to assess their impact on rural minority populations.

Recommendations

- Develop a program, task force and advisory group to assess reform policies in all states to gauge their impact on rural health.
- Expand and focus activities to other policies and legislation, including health care financing, regulations and training.

Tasks

Year 1

- Establish a database by developing methodologies or approaches for assessing policies.
- Assess the impact of policy by developing a methodology to ensure that assessment and data collection techniques are consistent, reliable, and culturally and linguistically appropriate.

Year 2

- Verify and validate the accuracy of the database established in Year 1 as an ongoing activity.
- Continue to assess the impact of policy by:
  - √ review of proposed assessment methodologies by funding sources and consultants as appropriate;
  - √ identify funding sources;
  - √ secure funding commitments; and
  - √ prepare and disseminate funding announcements.

Years 3 to 4

- Continue to assess the impact of policy by:
  - √ conducting studies; and
  - √ then preparing and disseminating the findings.

Year 5 and Beyond

- Continue to assess the impact of policy by:
  - √ evaluating and refining the process and outcomes of objectives and actions;
  - √ conducting a conference with researchers and stakeholders to review methodological approaches and results of reviews;
  - √ reporting findings; and
  - √ convening groups of community stakeholders to review assessment data and make further recommendations to guide policy development for rural minority populations.

Resources

Year 1

- Database resources:
  - √ Office of Management and Budget;
  - √ Agency for Health Care Policy and Research;
  - √ National Association of State Legislatures; and
  - √ Association of State and Territorial Health Officials.
- Policy assessment resources:
  - √ state, federal and private funding agencies; and
  - √ local and regional minority communities.

Year 2

- Database resources:
  - √ representatives from various minority communities.

Year 3 to 4

- Stakeholder partnerships continue.

Empowering the Community

Empower the multigenerational, rural minority community to enter into the health policy process as partners in the development of appropriate community health systems.

Recommendations

- Engage consumers in informing and influencing public, community and institutional policies.
- Facilitate and enhance the development of appropriate rural minority community health systems.
- Fund rural minority health outreach efforts.
- Cultivate skills, awareness and involvement from communities.

Tasks

Year 1
- Educate communities by:
  - √ developing strategies for educating (in the form of a curriculum) and methods for enrolling community residents in the program offering; and
  - √ conducting a pilot test of the community-focused education strategy.
- Facilitate development of systems by:
  - √ developing an approach to implement and evaluate this objective; and
  - √ conducting a pilot test of the systems development approach.

Year 2
- Continue to educate communities by:
  - √ continuing pilot studies of the community-focused education strategy; and
  - √ evaluating and refining methods and content in the curriculum.

Years 3 to 5
- Continue to educate communities by:
  - √ implementing programs; and
  - √ evaluating and refining the process and outcomes, considering changing community dynamics.
- Continue to facilitate development of systems by:
  - √ continuing the efforts that were pilot tested; and
  - √ evaluating and refining the process and outcomes of the objective and activities.

Long-range Plan
- Maintain awareness of the political environment and its implication for rural minority health.

Resources

Year 1
- Education of communities resources:
  - √ state offices of rural health;
  - √ offices of minority health (state and federal);
  - √ the National Rural Health Association;
  - √ the Office of Rural Health Policy, HRSA;
  - √ the Bureau of Primary Health Care, HRSA;
  - √ state health departments;
  - √ area health education centers (AHECs); and
  - √ university cooperative extension services.
- Systems development resources:
  - √ telecommunication, web sites and databases;
  - √ farm organizations (Farm Bureau, Farmers Union, etc.); and
  - √ representatives from various minority communities.

Years 3 to 5
- Religious (faith) communities.
- Grassroots coalitions.
- Professional organizations.
- Office of Minority Health resource center.

Flexible Systems

Enhance, modify or develop a health services system that is flexible enough to respond to the changing needs of multigenerational rural minority communities through ongoing evaluation and restructuring of service delivery.

Recommendations

- Develop databases for agencies to respond and recognize changing needs of rural minority communities.
- Evaluation will be an ongoing component of the health care system's outcomes and research. Evaluation data will be utilized for future planning and for restructuring health services and human delivery models to more effectively meet the needs of rural communities.

Tasks

Year 1
- Encourage ongoing evaluation; push for a 10 percent evaluation funding and set aside dollars in all grants and projects using those revenues to target multigenerational, rural minority populations.
- Restructure systems through the development of national and regional councils of lay reviewers of evaluation results that will convene semi-annually.

Year 2
- Encourage ongoing evaluation by continuing efforts to increase quantity and quality of evaluation.
- Initiate a strategy for disseminating evaluation results and recommendations regarding restructuring policies.

Year 3 and Beyond
- Continuation of above activities.

Resources

- Public and private funding agencies.
- Representatives from various rural minority communities.
- Stakeholder partnerships continue.

Holistic Focus

Promote an environment that improves the public health and maintains the safety of rural minority communities through a holistic focus, inclusive of sustained economic development, education, infrastructure and resource management.

Recommendations

- Assess and specify aspects of infrastructure and environment that are threats to the well-being of rural minority communities.
- Involve federal and community agencies, leaders and people from all sectors to develop a coordinated strategy aimed at maintaining and promoting the public health and safety of residents in rural minority communities.
- Allow local control and minority input in the decision-making process.

Tasks

Year 1
- Identify agencies that have a role in the health and safety of the public.
- Form and facilitate partnerships that actively involve the community of interest to improve its overall health status.
- Secure funding from appropriate sources to plan and implement culturally sensitive assessments, programs and evaluation strategies to measure outcomes on specific rural minority communities of interest.
- Disseminate findings in culturally and linguistically appropriate ways, specific to the target audience or agency.
- Evaluate and refine processes and outcomes of objectives and activities.

Resources

Year 1
- Environmental Protection Agency.
- Public health departments.
- National Rural Development Council.
- State Rural Development Council.
- Representatives from various rural minority communities.
- Stakeholder partnerships continue.

Quality of Life

Monitor the implementation of any policy reform to secure and maintain quality of life within the multigenerational, rural minority community.

Recommendations

- Build and maintain a database of policy reform changes in rural minority communities at the state and territorial level.
- Commission and collect assessments of those changes at the community level in the states and territories.
- Have an advisory board review the complete database and make recommendations for use of reform strategies that will help to improve the quality of life of rural minorities.
- Rural minority issues should be integrated into all of the NRHA's constituency groups' work plans.
- Establish the Rural Minority Health Advisory Committee as a standing committee within the NRHA.

Tasks

Year 1
- Assessment of welfare reform policies.
  - √ Develop culturally and linguistically appropriate methodologies and approaches to assess policies.
- Build a database on welfare reform policies.
  - √ Identify, contact and enroll appropriate state and national organizations that actively are monitoring welfare reform policies.
  - √ Develop a strategy for collecting information and critical data for each state and territory that results in a consistent and uniform database at all levels.
- Community development.
  - √ Involve all relative coalitions.
  - √ Identify gaps not covered by those coalitions.

Year 2

- Continue to assess welfare reform policies.
  - √ Identify funding sources.
  - √ Secure funding commitments.
  - √ Prepare and disseminate funding announcements.
- Use of results.
  - √ Convene a panel of stakeholders with community-level representation.
- Community development.
  - √ Involve the National Advisory Committee on Rural Health and a subcommittee on rural minority health as a mechanism for reporting by coalitions.
  - √ Establish routine communication channels between the rural community development groups and the rural health group.

Years 2-5

- Enhance the database on welfare reform policies.
  - √ Collect and assimilate information about changes in welfare policies in all states and territories as an ongoing activity.

Year 3

- Continue to enhance the database on welfare reform policies.
  - √ Verify the information via feedback from contacts with rural minority people in the various territories and states as an ongoing activity.

Years 3-5

- Assessment of welfare reform policies.
  - √ Conduct studies.
  - √ Disseminate findings.
- Use of results (these activities will be ongoing).
  - √ Stakeholders meet bi-annually to deliberate and disseminate findings.
  - √ Evaluate the impact of this initiative (formative and summative) as well as the process and outcomes used to achieve this objective.

Resources

Year 1

- Build a database on welfare reform policies.
  - √ State welfare program offices and centers.
  - √ Independent and institutionally based researchers.
  - √ Research centers or firms.
  - √ Urban Institute.

Year 2

- Assessment of welfare reform policies.
  - √ Representatives from various rural minority communities.
  - √ Stakeholder partnerships continue.
  - √ State, county and community development councils.
  - √ National Rural Development Council.

Health Delivery Systems

Health care is a right, not a privilege. Given this premise, health care delivery systems must be developed by the year 2002 that substantially improve the health status of rural minority populations. These health care services must :

- be linguistically and culturally appropriate for the community;
- be based on the assessed needs of the community;
- be responsive to the community's input;
- be linked to other health and community systems;
- be cost effective;
- provide access to all rural minority populations;
- improve the health status of rural minority populations; and
- offer a network of services and systems.

Issues of Concern

One of the weakest links, if not the weakest link, in the American health care chain is rural minority populations. The number of uninsured, underinsured and temporarily insured minorities is rapidly increasing, and the current model of employment-based health insurance is eroding.

Current health services, programs and systems are not culturally and linguistically appropriate, resulting in many unmet health needs of rural minority populations.

Members of rural minority communities are not asked for their input in community needs assessments, nor are they informed about research on their health or health care. Additionally, rural minorities are not included in decision-making processes about how their health system functions.

Health services and programs in rural minority communities tend to be created and operated independently, rather than in unison with other services, programs and systems. This uncoordinated approach results in gaps, duplication of services and waste of scarce resources.

Needs assessments of communities and minority populations for the most part are outdated, not ongoing or not culturally sensitive.

Improve Rural Minority Communities' Health Status

Available health-related data clearly support the notion that one of the weakest links, if not the weakest link, in our health care chain is in the rural minority population where the numbers of uninsured, underinsured and temporarily insured are growing, and the model of employment-based health insurance is eroding. The health status of rural minority communities already is in a state of crisis. Furthermore, health delivery systems generally are not put in place with the goal of improving the health status of these communities. If these health delivery issues are not addressed soon, the results will be disastrous in many of our rural minority communities. There is a national movement emerging to convert Medicaid from an entitlement program to a state block grant model. Given that all minorities are not treated equal, and that states are faced with the constraint of balancing budgets, the Medicaid restructuring movement probably is the greatest threat to the overall health status of our rural and minority communities. Therefore, we must develop health care delivery systems that can achieve the following recommendations.

Recommendations

- Improve the health status of rural minority communities.
- Establish and strengthen safety net health care providers.
- Increase access to culturally and linguistically appropriate minority health care.
- Empower minority health consumer groups and local leaders to become involved in the development of health care delivery systems in their communities.
- Decrease physical, financial, institutional and psychological barriers to health care.
- Build bridges between existing health care delivery services and other formal and informal community support systems to maximize the efficacy of the local delivery system.

Summary

The goal is to decrease the incidence of preventable illness, diseases, injuries and excessive death rates of rural minority populations by 25 percent by the year 2002.

Tasks

Year 1

- Articulate the need to legislators for increased funding support for the National Health Service Corps (NHSC) to increase minority health providers in rural areas.
- Assess the viability and scope of existing health care systems. Clearly document resources and models that work.
- Incorporate issues of rural minority populations into *Healthy People: 2000*. Add goal statements for minority populations in this document.
- Analyze available national and state health-related data and information to identify and clearly document rural minority communities' and populations' health idiosyncrasies.
- Establish ongoing Centers of Excellence across the nation that focus on rural minority populations' health issues.
- Increase linkages and utilization of telemedicine and telehealth and distance education technology to offer education and consultation to rural providers and minority communities as a way of improving access to timely information in isolated rural communities.
- Strategically plan and develop a framework for increasing public awareness and commitments for action to address rural minorities' health care delivery concerns.
- Identify and analyze rural models that work, replicate or tailor these to fit the cultural and linguistic preferences of other minority communities.

Year 2

- Identify and develop peer educators so that there are a greater number of culturally sensitive trained personnel and resources available to minority communities.
- Establish a task force to plan and implement rural minority health initiatives, oversee activities that are delineated in this five-year strategic plan, and track and monitor the rural minority health action agenda.
- Educate policy-makers, local providers and health outreach providers to be more sensitive to the values and needs of the rural minority communities they serve so that they can deliver culturally and linguistically appropriate care.
- Emphasize the concept of community-oriented primary health care as a proven strategy to improve the health status of rural minorities.
- Increase the number of women receiving prenatal care in their first trimester of pregnancy to lower infant morbidity and mortality rates in rural minority communities.
- Expand existing systems and programs where they are inadequate or nonexistent to improve delivery and increase utilization of services, i.e., hours of operation.
- Place peer educators in the community (field) to educate, involve and empower community members to assume responsibility and participate in decisions about their health and health care.
- Mobilize public and community health nurses, allied health personnel, educators and physicians to teach consumers about health promoting behaviors and to screen and make referrals for chronic health concerns (e.g., diabetes, nutrition, counseling, cancer symptom management, chronic respiratory and cardiac problems). This strategy can help to detect diseases earlier, manage chronic health problems and increase personal responsibility for health.
- Develop and support community-based volunteer alliances to empower rural minority populations to be more involved in identifying and addressing their health needs in the decision-making process. Utilize the media to create and promote community awareness of health-related issues.
- Develop and expand school-based health care programs, improve access and provide culturally appropriate services.

Year 3

- Continue to expand and evaluate programs and services—and their outcomes—that were initiated in the previous two years.
- Implement health risk assessment programs that include, but are note limited to mental health and illness, domestic and community violence, and personal lifestyle behaviors as a strategy to reduce emergency and long-term injuries and trauma in rural minority populations.
- Evaluate existing and recently developed programs and services to ensure these are tailored to the communities' cultural and linguistic preferences.
- Establish adult day care programs to meet the needs of the aging rural minority population.
- Introduce pilot programs, services and projects to see if these will work in a given community. Evaluate, refine and modify these to ensure that there is an appropriate cultural fit.

Year 4 and Beyond

- Utilize military reserve health care personnel and facilities as a temporary but regular source of health care providers in health professional shortage, unserved and underserved communities (e.g., weekend

drills, annual training, etc.). These people can operate clinics and provide other essential services in rural minority communities.
- Evaluate process and outcomes; refine and modify programs and services as needed.

Resources

Year 1
- Articulate the need to legislators....
  - √ National Rural Health Association.
  - √ Federal government.
  - √ Grant-funding agencies.
- Assess viability and scope of existing systems.
- Incorporate issues of rural minority populations into *Healthy People: 2000.*
  - √ Federal government.
  - √ National Rural Health Association.
  - √ Partnering of local community and academia and centers of excellence.
  - √ Indian Health Service for American Indian communities.
- Analyze available national and state health-related data and information....
  - √ Obtain grant funding.
- Establish ongoing Centers of Excellence...
  - √ Office of Rural Health Policy.
  - √ Health Resources and Services Administration.
  - √ Federal and state funding sources.
- Increase linkages and utilization of telemedicine and telehealth and distance education technology...
  - √ Federal, state and private funding sources.
  - √ NRHA Rural Minority Health Work Group.
  - √ NRHA Rural Minority Health Advisory Committee.
  - √ Centers for Disease Control and Prevention.
  - √ National Center for Farmworker Health.
  - √ Office of Minority Health.

Year 2
- Identify and develop peer educators....
  - √ Migrant Clinicians Network.
  - √ Partnerships between the CDC and local health providers.
- Establish a task force....
  - √ National Center for Farmworker Health.
  - √ Federal agencies.
  - √ Federal grants and state and local support.
- State and local health departments.
- Indian Health Service for Native American communities.
- Educate policy-makers, local providers and health outreach providers.... Emphasize the concept of community-oriented primary health care as a proven strategy.... Increase the number of women receiving prenatal care.... Expand existing systems and programs where they are inadequate or nonexistent....
  - √ Local resources.
  - √ Representatives from the communities.
  - √ Partnering of rural health clinics and community and migrant health centers.
  - √ Migrant health centers.
  - √ Women, Infants and Children program services.
  - √ Solo health professional in the community.
  - √ Federal, state and local funds.
- Place peer educators in the community (field)....
  - √ Migrant Clinicians Network.
  - √ Local community, civic and service organizations.
  - √ Faith community.
  - √ Bureau of Primary Health Care, HRSA.
- Mobilize public and community health nurses, allied health personnel, educators and physicians to teach consumers....
  - √ Professional and allied health schools.
- Develop and support community-based volunteer alliances to empower minority populations....
  - √ State and federal agencies.
  - √ Health Resources and Services Administration.
- Develop and expand school-based health care programs, improve access and provide culturally appropriate services.
  - √ Educators in local schools.
  - √ Representatives from the community.
  - √ Community service and civic groups.

Year 3
- Continue to expand and evaluate programs and services....
  - √ Community and migrant health centers.
  - √ Rural health clinics (RHCs).
  - √ Federally qualified health centers (FQHCs).
  - √ Local providers.
  - √ Indian Health Service providers.
- Implement health risk assessment programs....
  - √ Health professionals from all disciplines who are available to provide services in rural minority communities.
- Evaluate existing and recently developed programs and services.... Establish adult day care programs....
  - √ Federal, state and local (community) agencies.
  - √ Public and private institutions.
  - √ Federal grants.
  - √ Foundation and philanthropic donations.
  - √ Medicare, Medicaid and other third-party payers.
  - √ American Association of Retired Persons.
  - √ Aging services.
- Introduce pilot programs, services and projects....
  - √ Representatives from the community.

Year 4 and Beyond

- Department of Defense.
- Local military reserve units.
- Representatives from the community.
- Health care providers.
- Federal, state and local policy-makers.

Increase Access to Culturally and Linguistically Appropriate Health Care Services and Systems for Rural Minority Communities

Even through there is limited data and information on rural minority residents, that which does exist shows that these populations do not have the same level of access to basic primary health care services. This deficit is reflected in the health status indicators of rural minority populations. Compounding those unfortunate circumstances is the realization that basic primary health care services often are not culturally and linguistically appropriate for a given community. This finding can be attributed to a range of factors, including a provider's lack of knowledge, inappropriate service delivery or general insensitivity to the cultural values and beliefs of a particular community. Stemming from their background and innate knowledge, overall minority health care providers are able to deliver more appropriate and effective care to their communities. To improve the quality of and access to services in rural minority communities, educational institutions must be encouraged to increase the numbers of minority students that are admitted into and that graduate from health professional programs. Likewise, health professionals in general must be educated about cultural and linguistic dimensions of minority communities and clients who live in rural areas of the United States.

Recommendations

- Increase the numbers of culturally and linguistically appropriate health care providers in rural minority communities.
- Empower individuals to become involved in decision-making that can influence health care delivery systems.
- Decrease physical, financial and institutional barriers to health care.

Tasks

Year 1

- Develop orientation programs that inform and sensitize providers to the community. Increase minority membership in the NRHA.
- Identify community leaders who are willing and able to be involved in the development of health care delivery systems.
- Develop a list of community experts for various community empowerment activities (e.g., speakers bureau, program development, community building, etc.).
- Evaluate, refine and modify the processes and outcomes of the above efforts on an ongoing basis.
- Ensure that uninsured and underinsured populations have adequate access to appropriate health care.

Year 2

- Develop policies that foster community partnerships, emphasize improvement of its health status and create public awareness of rural minority issues.
- Develop a cadre of human resources to inform and educate the rural minority population about particular community concerns and to increase available resources.
- Improve and increase the number of existing programs to identify rural minority junior high and high school students who are interested in health careers.
- Identify and mentor rural minority junior high and high school students interested in health careers. Emphasize and provide role models about the importance of returning to their rural communities upon completing their educations.
- Start rural minority mentorship programs with health professionals who return to their communities.

Year 3

- Create awareness in academic institutions, influence curriculum development to include cultural and linguistic content in health professional educational programs, and standardize curricula to include this dimension of health care delivery in all settings, particularly in rural and minority communities.
- Conduct focused recruitment efforts that target culturally and linguistically appropriate providers.

Year 4 and Beyond

- Encourage and facilitate rural-based educational experiences in health professional programs (e.g., nursing, medicine, allied health) to increase the number of providers who elect to work in this environment upon completing their programs of study.
- Enroll minority consumers in the NRHA.
- Evaluate, refine and modify preceding activities in relation to processes and outcomes.

Resources

Year 1

- Develop orientation programs that inform and sensitize providers....
  - √ National Rural Health Association.
  - √ Area health education centers (AHECs).
  - √ National Health Service Corps.
  - √ Local groups.
- Identify community leaders who are willing and able to be involved in the development of health care delivery systems.
  - √ Representation from the community of interest.
- Develop a list of community experts....
  - √ Health Resources and Services Administration.
  - √ Area health education centers (AHECs).
- Ensure that uninsured and underinsured populations have adequate access to appropriate health care.
  - √ Department of Health and Human Services.
  - √ Health Resources and Services Administration.

Year 2

- Develop policies that foster community partnerships, emphasize improvement of its health status and create public awareness of rural minority issues.
  - √ Federal and local Centers of Excellence.
  - √ Grants.
- Develop a cadre of human resources to inform and educate the rural minority population....
  - √ Partnering between local health professionals and community leaders, school administrators and educators, the faith community, and institutions of higher learning and universities.
  - √ Health Resources and Services Administration.
- Improve and increase the number of existing programs.... Identify and mentor rural minority junior high and high school students.... Start rural minority mentorship programs with health professionals....
  - √ Health Resources and Services Administration.
  - √ Bureau of Health Professions.
  - √ Elementary, secondary and post-secondary schools.
  - √ Institutions of higher learning and universities.
  - √ National, state and local chapters of health professional organizations such as the American Nurses Association, American Medical Association and Indian Health Service.
  - √ National Rural Health Association.

Year 4 and Beyond

- Include and partner with representatives from rural minority communities.
- National Rural Health Association.

Build Bridges Between Existing Health Care Systems and Other Community and Social Services to Maximize Utilization of Resources.

Currently, there are a variety of programs, services and systems in place in rural regions that are reported to serve the health care needs of minority populations. Most of these programs operate independently of other existing health care services in the community, such as social services, public and private health care programs and informal support systems. Often, these entities have separate personnel, documentation and application forms, funding, program objectives, and even clientele. This approach, often competitive in nature, results in a patchwork model of service delivery. Ultimately, it is haphazard and omits or neglects the needs of large segments of the minority population. Therefore, there must be a concerted effort to increase and improve communication between community services and programs in a regular and ongoing manner. The overall goal of all these community entities should be the restructuring of services to address service gaps, thereby creating a seam-free continuum of services for minorities in underserved rural regions of the United States. Outcomes of this partnering effort could be more effective use of limited resources, improved access to care and healthier rural minority communities in the future.

Recommendations

- Increase linkages between rural communities, other community health resources, academic institutions, federal programs, government-sponsored service programs and military facilities.

Tasks

Years 1 to 3

- Negotiate strategies with managed care organizations to assess and identify a role for other local health care service delivery organizations.
- Develop a geographic information system (GIS) map of rural communities to identify patterns and trends of disease, injury and other health problems in minority populations.
- Identify and establish partnerships between local, state, federal and private programs and entities to coordinate a continuum of essential services for rural minority communities that are culturally and linguistically appropriate.
- Establish linkages with rural development councils and agencies and Empowerment Zones/Enterprise Communities to increase employment opportunities, thus improving the socioeconomic status of impoverished

minority communities, which ultimately will affect their health status.

Year 4
- Continue partnering efforts and activities.
- Evaluate, refine and modify processes and outcomes of all the activities for these objectives.

Resources

Years 1 to 3
- Community and migrant health centers.
- Rural health clinics (RHCs).
- Federally qualified health centers (FQHCs).
- Local community organizations.
- Managed care organizations, health maintenance organizations, and preferred provider organizations.
- Bureau of the Census (national and state).
- Other federal, state, local, public and private entities as appropriate.
- Representatives from the rural minority communities.
- National Rural Health Association.

Year 4
- Local business entities and representatives from minority communities.
- National Rural Health Association.

Appendix A—Anatomy of a Recommendation

Who	Always to the secretary of the Department of Health and Human Services (DHHS).
With Whom	Other cabinet departments, federal agencies, state and local governments, etc.
What	What is it we are asking the secretary of DHHS to do?
How	How is the secretary of DHHS to act? • Propose legislation? • Propose or change regulations? • Make an administrative decision? • Make a funding decision? • Program coordination? • Conduct a cooperative endeaver with third parties (states, foundations, etc.)?
When	Is there a specific time frame for action (i.e., in response to a regulation, bill or law)?
Where	On national, state or local levels.
Why	The rationale behind the recommendation. • Must be adequately researched. • Must know what is already being done—or not being done. • Must present evidence of the problem to be addressed.
Balance	Striking a balance between the ideal and the attainable is the art of propsoing effective and feasible policy or action.

Each recommendation should be preceded by a preamble or an introductory statement explaining or laying the foundation for a set or recommendations designed to address issues brought out in the preamble. As they are currently written, the recommendations appear to be a wish list of things that would be nice to do, but there is no indication of how they would be implemented.

Appendix B—Terminology Used in Conjunction With Rural Minority Health

Acceptable (health services)
Best practices/best models
Community assessment
Community assets
Culturally competent
Environment
Environmental infrastructure micro/macro
Family
Health care system
Health services 1-3 degree across life span
Holistic
Homeless
Inclusion/inclusive
Isolated persons
Institutional policy
Linguistically appropriate
Local control
Local health care system
Marginalized populations
Medicaid
Medicare
Multigenerational
Primary organizations
Public policy
Refugee
Resources
Racial/ethnic minorities/racism
Socially and economically disadvantaged
Traditional/non-traditional participants
Underinsured
Underserved
Undocumented
Uninsured

Appendix C—Final Conference Participant List

National Rural Health Association
3rd Annual Rural Minority Health Conference
"Rural Minority Health: Issues for the 21st Century
December 11-13, 1997
Charleston, South Carolina

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Appendix E—
Conference Program

3rd Annual

RURAL MINORITY

Health Conference

Rural Minority Health:

ISSUES *for the* 21ST CENTURY

A Working Conference

Conference Program

December 11-13, 1997
Sheraton Charleston Hotel
Charleston, South Carolina

Supported by:
Office of Rural Health Policy • Bureau of Primary Health Care
Health Resources and Services Administration

Corporate Sponsor:
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South Carolina State Office of Rural Health
South Carolina Primary Health Care Association
South Carolina Academy of Family Physicians
South Carolina Department of Health and Environmental Control,
Office of Minority Health

NATIONAL RURAL HEALTH ASSOCIATION

PROGRAM

Thursday, December 11, 1997

7:30 a.m. - 9:00 a.m.

Registration—*Promenade*

9:00 a.m. - 9:15 a.m.

Welcome/Overview
Room: Cotillion A
Speakers: *Donna M. Williams,*
Executive Vice President
National Rural Health Association
Kansas City, Missouri
Arlene Granderson, M.P.H.,
Director of Operations
Office of Rural Health Policy, HRSA
Rockville, Maryland

9:15 a.m. - 9:30 a.m.

Opening Session
Room: Cotillion A
Speaker: *Sharon Barrett, M.S., Director*
Office of Minority and Women's Health
Bureau of Primary Health Care, HRSA
Bethesda, Maryland
This session will provide the rationale and goals of the Rural Minority Health Work Group, describing ways to implement the action agenda the work group has developed.

9:30 a.m. - 10:15 a.m.

Keynote Session
Room: Cotillion A
Moderator: *Sharon Barret, M.S., Director*
Office of Minority and Women's Health
Bureau of Primary Health Care/HRSA
Bethesda, Maryland
Speaker: *Rueben Warren, D.D.S., Dr.P.H.,*
Associate Administrator, Urban Affairs
Agency for Toxic Substance
and Disease Registry
Atlanta, Georgia
This session will provide an energetic beginning to the conference, giving participants the mind-set to meet the challenges of collaboration and partnership presented by the strategic plan of the Rural Minority Health Work Group.

10:15 a.m. - 10:30 a.m.

Break—*Promenade*

10:30 a.m. - 12:30 p.m.

Panel Discussion
Room: Cotillion A
"Rural Minority Health: Implications for Policy and Practices"
Moderator: *Donna M. Williams*
Executive Vice President
National Rural Health Association
Kansas City, Missouri
Speaker: *Patricia Matthews Juarez,*
Ph.D., Chief Financial Officer,
Health Operations Management Enterprises
Los Angeles, California
Juarez will discuss managed care issues relevant to rural minority populations and strategies to implement successful programs.

"Rural Minority Health Information and Data"
Speaker: *Patricia M. Golden, M.P.H.,*
Special Assistant to the Director
Office of Analysis, Epidemiology and
Health Promotion
National Center for Health Statistics
Hyattsville, Maryland
Golden will discuss what data is available, how to use that data, and ways to work with census data and other data that focus directly on rural areas.

"Rural Health Care Delivery Systems: Minority Policy Relevant Issues"
Speaker: *Lawren Sanders Jr., M.D., M.B.A.,*
Vice President, Medical Affairs/
Medical Director
Southwest Hospital and Medical Center
Atlanta, Georgia
Sanders will discuss problems of managed care and its affect on providers who are offering services to rural minority populations.

12:30 p.m. - 1:30 p.m.

Lunch Program
Room: Cotillion C
Moderator: *Rosemary McKenzie*
Senior Staff Specialist
National Rural Health Association
Kansas City, Missouri
Speaker: *Gardenia Ruff, Director*
Office of Minority Health,
South Carolina Department of Health
and Environmental Control
Columbia, South Carolina
This session will provide an overview of the activities of the South Carolina Office of Minority Health, discussing partnership efforts and the necessity of sharing information. The program also will establish expectations for the work group sessions, propelling participants into the afternoon's activities.

1:30 p.m. - 1:45 p.m.

Orientation of Work Group Tasks and Processes
Room: Cotillion A
Speaker: *Walter Morgan, Ph.D., C.M.C.,*
Morgan Management Systems Inc.
Columbia, Maryland

Participants will be given an overview of the Rural Minority Health Work Group organization and structure to facilitate the selection of group leaders, recorders, reporters and individual assignments for each work group. Understanding the task assignments, preparing for the task, reviewing resource materials, and using resource people will be discussed.

1:45 p.m. - 3:00 p.m.

Work Group Activities

Attendees will select one of the following three work groups for this and subsequent work group sessions. The charge for each work group is to examine the listed issues and develop implementation strategies and recommendations for a plan of action. Each work group will be divided into subgroups to focus specifically on one issue.

A. Health Delivery Systems Issues
Room: Cotillion A
Facilitator: Monnieque Singleton, M.D.
Resource Person: Lawren Sanders Jr., M.D., M.B.A.

This work group will be charged with developing strategies and recommendations to:

- Improve the health status of rural minority communities.
- Increase access to culturally and linguistically appropriate health care.
- Build bridges between existing health care systems and other community and social services to maximize utilization of resources.

B. Information and Data Issues
Room: Citadel A
Facilitator: Ruth Perot
Resource Person: Patricia M. Golden, M.P.H.

This work group will be charged with developing strategies and recommendations to:

- Define the terms "rural," "minority" and "migrant" to eliminate multiple definitions. Variations in use interfere in the ability to compare aggregate data within and across studies.
- Develop methods to gather data and information for health issues of concern to all rural minority communities. National health surveys and census data often are not analyzed to address smaller rural minority communities and populations, or they are inadequate or incorrect because the findings do not reflect a group's unique cultural perspectives.
- Promote the timely collection, dissemination and use of data for minority populations. Research data on rural minority communities are extremely time-sensitive due, in part, to these populations' high growth rates and migration patterns.
- Promote the use of "over-sampling" techniques in data collection efforts to obtain and include the perspectives of small numbers of rural minority populations. Major data gaps exist about rural minorities with respect to environmental effects, their particular health-related needs, essential "wrap-around" services and health status and outcomes.
- Identify research methods that are culturally appropriate or linguistically reliable for rural minority communities. Researchers who collect data in rural minority communities often do not inform the community or involve it in planning the design of the study, thus failing to reflect the unique cultural concerns of a community in the collected data.

C. Health Policy and Practices Issues
Room: Citadel B
Facilitator: Thomas Ricketts, Ph.D.
Resource Person: Patricia Matthews Juarez, Ph.D.

This work group will be charged with developing strategies and recommendations to:

- Develop mechanisms that are appropriate for use by health care delivery systems to achieve comprehensive health care services for multigenerational minority populations.
- Identify marginalized populations (uninsured, underinsured, Medicaid, Medicare, undocumented persons, refugees) for inclusion within the network of care.
- Identify and review existing legislative policies at all levels to evaluate their impact on rural minority health care to facilitate reorganization and formation of complementary systems of care.
- Empower the multigenerational rural minority community to enter into the legislative process as partners in the development of appropriate community care systems.
- Redesign the health care system to one that is flexible enough to respond to the changing needs of multigenerational rural minority communities through ongoing evaluation and restructuring of service delivery.
- Promote an environment that improves the public health and maintains the safety of rural minority communities through a holistic focus inclusive of sustained economic development, education, infrastructure and resource management.
- Monitor the implementation of welfare reform to secure and maintain quality of life within the multigenerational, rural minority community.

3:00 p.m. - 3:15 p.m.

Break—*Promenade*

3:15 p.m. - 4:45 p.m.

Work Group Activities (continued)

Friday, December 12, 1997

8:00 a.m. - 9:00 a.m.

Registration—*Promenade*

9:00 a.m. - 9:15 a.m.

Overview of Work Group Implementation Tasks: Strategies and Recommendations for Year One
Room: Cotillion A
Speaker: *Walter Morgan, Ph.D., C.M.C., Morgan Management Systems Inc. Columbia, Maryland*
Participants will be given the opportunity to clarify anyof the work groups' questions and concerns, to develop mutual understanding of the task assignments and expectations, and to discuss the planning materials and support and resources available.

9:15 a.m. - 10:45 a.m.

Work Group Activities
(continued from Thursday in same rooms)

10:45 a.m. - 11:00 a.m.

Break—*Promenade*

11:00 a.m. - 12:10 p.m.

Development of an Implementation Strategy for the Key Issue(s): Year One
(continued from Thursday in same rooms)
During this session, each subgroup's input will be reconciled; the work group's reconciled implementation strategy, recommendations and plan for Year One will be prepared; and each work group's report will be developed.

12:30 p.m. - 1:30 p.m.

Lunch Program
Room: Cotillion A
Moderator: *Monnieque Singleton, M.D. Denmark Medical Center Denmark, South Carolina*
Speaker: *Representative James E. Clyburn (Democrat, 6th District, South Carolina), Washington, D.C.*
This session will address national issues regarding rural minority populations and focus on strategies that should be implemented to achieve access to health care for rural minorities.

1:45 p.m. - 3:00 p.m.

Development of an Implementation Strategy for the Key Issue(s): Year One
(continued from Thursday in same rooms)
Continuation of implementation strategies, recommendations, Year One plan, and work group report development.

3:00 p.m. - 3:15 p.m.

Break—*Promenade*

3:15 p.m. - 4:45 p.m.

Development of an Implementation Strategy for the Key Issue(s): Year One
(continued from Thursday in same rooms)
Continuation of implementation strategies, recommendations, Year One plan, and work group report development.

Saturday, December 13, 1997

9:00 a.m. - 9:15 a.m.

Overview of Implementation Strategy Accomplishments
Room: Cotillion A
Speaker: *Walter Morgan, Ph.D., C.M.C., Morgan Management Systems Inc. Columbia, Maryland*

9:15 a.m. - 11:15 a.m.

Reporting of Implementation Strategies and Recommendations by Work Groups
Room: Cotillion A
Each work group will report to all participants its implementation strategies and recommendations for Year One as well as recommendations for partnering and funding.

11:15 a.m. - 11:30 a.m.

Break—*Promenade*

11:30 a.m. - 12:00 noon

Closing Comments
Room: Cotillion A
Speakers: *Tim Size, NRHA President Executive Director Rural Wisconsin Health Cooperative Sauk City, Wisconsin*
Dianne Sutton, President Sutton Enterprises Washington, D.C.

12:00 noon

Adjourn

Appendix F—Bibliography

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